# Summary of the Continuation Coverage Premium Reduction Provisions under ARRA

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced continuation coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an Assistance Eligible Individual and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

**♦ IMPORTANT ♦**

- ◊ If, after you elect continuation coverage and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◊ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◊ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding continuation coverage you should contact your former employer, who is responsible for administering continuation coverage under the plan.

For specific information related to your plan's administration of the ARRA Premium Reduction or to notify the issuer of your ineligibility to continue paying reduced premiums, contact ConnectiCare at: 1-800-333-1733.

If you are denied treatment as an Assistance Eligible Individual you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.cms.hhs.gov/COBRAContinuationofCov or NewCobraRights@cms.hhs.gov

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

## Section 1A – Request for treatment as an assistance eligible individual

**To apply for ARRA Premium Reduction, complete this form and return it to your former employer along with your Election Form, (Section 2A if applicable.)**

**You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: your former employer. Please ask your former employer to put their contact information below.**

**You may also want to read the important information about your rights included in the "Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA."**

| Employer Name: | Employer Mailing Address |
|---|---|
| _____ | _____ |
| | _____ |

## PERSONAL INFORMATION

| Name and mailing address of employee (list any dependents on the back of this form) | Telephone number |
|---|---|
| | E-mail address (optional) |

To qualify, you must be able to check 'Yes' for all statements.

| | |
|---|---|
| 1. The loss of employment was involuntary. | ☐ Yes ☐ No |
| 2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009. | ☐ Yes ☐ No |
| 3. I elected (or am electing) continuation coverage. | ☐ Yes ☐ No |
| 4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium). | ☐ Yes ☐ No |
| 5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium). | ☐ Yes ☐ No |

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

## Section 1B – Covered dependents

**DEPENDENT INFORMATION** (Parent or guardian should sign for minor children.)

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

| | |
|---|---|
| 1. I elected (or am electing) continuation coverage. | ☐ Yes ☐ No |
| 2. I am NOT eligible for other group health plan coverage. | ☐ Yes ☐ No |
| 3. I am NOT eligible for Medicare. | ☐ Yes ☐ No |

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

| | |
|---|---|
| 1. I elected (or am electing) continuation coverage. | ☐ Yes☐ No |
| 2. I am NOT eligible for other group health plan coverage. | ☐ Yes☐ No |
| 3. I am NOT eligible for Medicare. | ☐ Yes☐ No |

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature ➔ _____ Date ➔ _____

Type or print name ➔ _____ Relationship to employee ➔ _____

---

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

| | |
|---|---|
| 1. I elected (or am electing) continuation coverage. | ☐ Yes☐ No |
| 2. I am NOT eligible for other group health plan coverage. | ☐ Yes☐ No |
| 3. I am NOT eligible for Medicare. | ☐ Yes☐ No |

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature ➔ _____ Date ➔ _____

Type or print name ➔ _____ Relationship to employee ➔ _____
(If you need space to list additional dependents please make a copy of this page and submit with this form.)

---

## Section 1C

**FORMER EMPLOYER MUST COMPLETE**

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)
Specify reason below and then return a copy of this form to the applicant. If this application is approved, send the original of this form to ConnectiCare, Attn: enrollment, at 175 Scott Swamp Road, Farmington, CT 06032

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

| | |
|---|---|
| 1. Loss of employment was voluntary. | ☐ |
| 2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009. | ☐ |
| 3. Individual did not elect continuation coverage. | ☐ |
| 4. Other (please explain here) | ☐ |
| 5. Employer is contributing $ _____ to coverage | |

**The employer has 19 or fewer employees and is subject to the state continuation laws ("mini"-COBRA) rather than federal COBRA law.**

Signature of person at employer responsible for continuation coverage administration for the Plan

x _____ Date _____

Type or print name _____

Telephone number _____ E-mail address _____

## Participant Notification

**This form is designed for ConnectiCare to distribute to qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify ConnectiCare if they become eligible for other group health plan coverage or Medicare.**

**Use this form to notify ConnectiCare that you are eligible for other group health plan coverage or Medicare.**

| | |
|---|---|
| ConnectiCare<br>Attn: Enrollment | 175 Scott Swamp Road, Farmington, CT 06032 |

## PERSONAL INFORMATION

| Name and mailing address | Telephone number<br><br>E-mail address (optional) |
|---|---|

## PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

| | |
|---|---|
| I am eligible for coverage under another group health plan.<br>If any dependents are also eligible, include their names below.<br>Insert date you became eligible_____ | ☐ |
| I am eligible for Medicare.<br>Insert date you became eligible_____ | ☐ |

## IMPORTANT

**If you fail to notify ConnectiCare of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced continuation coverage premiums you could be subject to a fine of 110% of the amount of the premium reduction.**

**Eligibility is determined regardless of whether you take or decline the other coverage.**

**However, eligibility for coverage does not include any time spent in a waiting period.**

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____ _____

_____ _____